

FATIMA AYDIN, PH.D.

Licensed Psychologist

617.869.2883

info@fatimaaydin.com

www.fatimaaydin.com

INITIAL INTAKE INFORMATION

Please complete the form below as fully as you can, attach a copy of the front and back of your insurance card and email everything back to me prior to our first session.

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

CELL PHONE: _____ OTHER PHONE: _____

EMAIL ADDRESS: _____

PREFERRED MEANS OF COMMUNICATION:

CELL _____ WORK PHONE _____ HOME PHONE _____ EMAIL _____ TEXT _____

INSURANCE

PRIMARY INSURANCE COMPANY: _____

NAME OF INSURED IF DIFFERENT FROM CLIENT: _____

DOB OF INSURED: _____ ADDRESS OF INSURED: _____

INSURANCE ID#: _____ GROUP#: _____

INSURANCE COVERAGE INFORMATION

ANNUAL DEDUCTIBLE: _____

CO-PAYMENT PER SESSION: \$ _____

AUTHORIZATION & AGREEMENT

1. I authorize payment of behavioral health benefits to my provider for services performed.

Signed: _____ Date: _____

2. I agree to contact my insurance provider and obtain relevant insurance coverage including the required co-payment and deductible.

Signed: _____ Date: _____

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PERSONAL HISTORY

DATE: _____

NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

CELL PHONE: _____ OTHER PHONE: _____

EMAIL ADDRESS: _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____

PHONE: _____

PLEASE INDICATE WHICH OF THE FOLLOWING ISSUES YOU ARE CURRENTLY EXPERIENCING OR HAVE EXPERIENCED IN THE PAST:

<input type="checkbox"/> Depression	<input type="checkbox"/> Sexual Identity
<input type="checkbox"/> Anxiety	<input type="checkbox"/> ADHD
<input type="checkbox"/> Grief	<input type="checkbox"/> PTSD
<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Abuse
<input type="checkbox"/> Trauma	<input type="checkbox"/> Relationship
<input type="checkbox"/> Self Harm	<input type="checkbox"/> Anger Management
<input type="checkbox"/> Addiction/Substance Use	<input type="checkbox"/> Bullying
<input type="checkbox"/> Academic Challenges	<input type="checkbox"/> Other:

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HAVE YOU SEEN A THERAPIST BEFORE? YES or NO (Please circle)

HAVE YOU BEEN PSYCHIATRICALY HOSPITALIZED IN THE PAST? YES or NO (Please circle)

IF YES, THE DATES AND LOCATIONS: _____

ARE YOU CURRENTLY TAKING MEDICATION? YES or NO (Please circle)

IF YES, PLEASE LIST YOUR MEDICATIONS AND THEIR DOSAGE?

NAME OF PRESCRIBER: _____

NAME OF PRIMARY CARE PHYSICIAN: _____

ADDRESS: _____

PHONE: _____

IS THERE ANYTHING ELSE THAT YOU WOULD LIKE ME TO KNOW TO BETTER SERVE YOUR NEEDS?

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AUTHORIZATION TO USE CREDIT CARD FOR PSYCHOTHERAPY SERVICES

I authorize Fatima Aydin, PhD to charge my credit card for the sole purpose of psychotherapy, consulting or counseling services rendered.

I authorize Fatima Aydin, PhD to use my credit card for the following purposes:

Copayments for Insurance covered visit(s) in the amount of: \$_____

Private Pay for psychotherapy/consulting session(s) in the amount of: \$_____

Missed appointments with less than 48 hours' notice in the amount of: \$150

Client Name (please print): _____

Client Address with zip code: _____

Credit Card: (circle one) **VISA, MASTERCARD, AMERICAN EXPRESS**

Credit Card#: _____

Exp. Date: _____

3-digit code: _____

Cardholder's Name (Please Print) _____

Signed: _____ Date: _____

Therapist Name (please Print) _____

Signed: _____ Date: _____

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FEES AND POLICIES

SELF-PAY AND REDUCED FEES

My self-pay fee is \$225 for a 50-minute Individual or Couples Therapy session. Reduced rates can be negotiated, depending upon my low-fee client load and other circumstances. If your financial circumstances change over the course of treatment, we may renegotiate the fee. My own fee may also go up over the course of a treatment that lasts more than one year.

INSURANCE

I am a provider for Blue Cross Blue Shield and Cigna Health Insurance. If you have a different insurance carrier, you can check with them to see if they cover out of network providers. If so, they would be able to reimburse you for our sessions.

BILLING

I accept credit/debit cards and would appreciate payment at each session.

CANCELLATIONS

Please give me a 48-hour notice of cancellation if you are unable to keep your appointment. There will otherwise be a charge of \$150 for the missed session or late cancellation.

CONFIDENTIALITY

I maintain a confidential record of your contacts with me. I will not reveal to anyone details about your consultation or therapy, or even the fact that you have met with me. There are also certain limits to the rule of confidentiality as specified by Massachusetts law. In the following instances, your records may be released without your permission:

1. If you are in danger of harming yourself or others
2. If a child, elderly or disabled person in your care is being abused and/or neglected
3. When a judge orders me to produce records or testify in connection with certain legal actions such as child custody, care and protection cases, adoption proceedings or rape and sexual abuse cases.

If, in the course of our work, we decide to meet with members of your family or friends, we will discuss the limits and expectations about confidentiality in advance.

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AGREEMENT

Your signature below indicates that you have read and agree to abide by the terms of our professional relationship described above.

Signature: Client or parent/guardian of minor child

Date

Signature: Client or parent/guardian of minor child

Date

Printed Name

Date

Clinician's Signature

Date